LUPUS™
Foundation of America
Philadelphia Tri-State Chapter, Inc.

Dear Lupus Self Help Course Applicant:

Thank you for your interest in participating in the Systemic Lupus Erythematosus Self Help Course.* This course is being provided free of charge by the Lupus Foundation of America, Philadelphia Tri-State Chapter through a grant from the PA Department of Health. The course will be conducted once a week for five weeks, with each weekly session being approximately 2 – 2 ½ hours. Dinner will be provided.

Topics covered include basic facts about lupus, medications, exercise, coping with pain and fatigue and much, much more. The program also provides participants an opportunity to share experiences, helpful hints and to discuss problems and solutions.

Upon successful completion of the course, participants will receive a free one-year membership to the Lupus Foundation of America, Philadelphia Tri-State Chapter. Membership includes a subscription to the Lupus Foundation of America's award winning magazine, **LUPUS NOW** and our local chapter newsletter, **Lupus Line.**

Because we expect great community interest, it is important that the enclosed forms be completed and returned to the Chapter office as soon as possible. Acceptance is on a first come first serve basis (e.g., the first 20 sets of completed forms received). In order to participate in the course, it is required that the Application Release Form be completed.

The "Dear Doctor" letter explains the course and the Physician Information Form is for your doctor to complete. **We suggest that this form is completed, but it is not required.** If you do not have an appointment with your doctor before the course begins, call his/her office, explain both forms to the receptionist, then mail or fax them both to the doctor's office. Your physician, in turn, can complete the form and return it to you by mail. When you receive this form, you can forward it to me or bring it with you to the first class meeting.

Confirmation of your registration and acceptance into the course will be provided prior to the first class. It is expected that you plan to attend each meeting and you are welcome to register a family member/friend to participate with you. The time and location of this course are listed below. If the course is full by the time your application is received, you will be placed on a waiting list and notified.

SLE Self- Help (SLESH) Course | Tuesdays: May 22, May 29, June 5, June 12, June 19, 2012 | 5:30-7:30pm
University of Pennsylvania, Penn Tower, 8th Floor Conference Room
3400 Civic Center Boulevard, Philadelphia, PA 19104

Thank you for your interest in the Lupus Self Help Course. We look forward to your participation. Please feel free to contact me at the chapter office if you need additional information.

Sincerely,

Caitlin R. Meeker, MPH
Community Development Manager

* The SLESH Course is a copyrighted program of the Arthritis Foundation, and is approved for use by the Lupus Foundation of America, Philadelphia Tri-State Chapter.

500 Old York Road, Suite 110 | Jenkintown, PA 19046
Toll Free in PA at 866-517-5070 |www.lupustristate.org | info@lupustristate.org

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Jenkintown, PA 19046
Toll Free in PA at 866-517-5070
215-517-5070 / Fax: 215-517-8483
www.lupustristate.org

Systemic Lupus Erythematosus Self Help (SLESH) Course Application Release Form

Please send your completed form to:

Lupus Foundation of America
Philadelphia Tri-State Chapter
500 Old York Road, Suite 110
Jenkintown, PA 19046

Date:_____

PRINT NAME_____
(FIRST) (LAST)

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____

EMAIL ADDRESS_____

BEST TIME OF DAY TO CONTACT ME IS_____

LOCATION OF CLASS: **University of Pennsylvania, Penn Tower, Philadelphia, PA 19104**

DOCTOR'S NAME_____

ADDRESS_____

If you are planning to bring a family member or friend, please provide his/her name:

_____

(Each participant must complete their own form).

If this application is accepted, I understand and agree that the Lupus Foundation of America, Philadelphia Tri-State Chapter will not have or assume any financial responsibility or liability for the expense of medical treatment or of compensation for any injury I may suffer during or resulting from participation in this course.

Signature _____

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Dear Doctor:

The Lupus Foundation of America, Philadelphia Tri-State Chapter is currently offering a five-week program, the Systemic Lupus Erythematosus Self Help (SLESH*) Course, for individuals living with lupus. The five-week program is a series of self-help classes that are offered free of charge through a grant from the Pennsylvania Department of Health. Course content includes:

- Self-help principles
- Information on lupus
- Exercise
- Joint protection/energy conservation/fighting fatigue
- Pain management
- Relaxation
- Medication principles
- Psychosocial aspects/problem solving
- Doctor-patient relationships
- Communication
- Non-traditional treatment evaluation

This program is approved by the Patient and Community Services Committee of the Lupus Foundation of America, Philadelphia Tri-State Chapter.

Your patient, _____, has indicated an interest in participation in this course. In order to better address the needs of this course applicant, we need your assistance. We ask that you complete the enclosed form, return it to your patient, who in turn will forward it to us. Your treatment program for him/her will not be altered and any questions concerning it will be referred to you.

If you have any questions about any aspect of the program, please feel free to contact me at the chapter office at 215-517-5070 or toll-free at 866-517-5070 in PA, NJ & DE.

Thank you in advance for your cooperation.

Sincerely,

Caitlin R. Meeker, MPH
Community Development Manager

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PHYSICIAN INFORMATION FORM

PATIENT'S NAME_____

PATIENT'S TELEPHONE NUMBER_____

DIAGNOSIS_____

_____

Please indicate if there are any special precautions or restrictions regarding this person participating in the Systemic Lupus Erythematosus Self Help Course:

_____

_____

_____

_____

PHYSICIAN'S NAME (PRINTED)_____

PHYSICIAN'S SIGNATURE_____DATE_____

OFFICE ADDRESS_____

TELEPHONE NUMBER_____

PLEASE RETURN THIS FORM TO YOUR PATIENT.